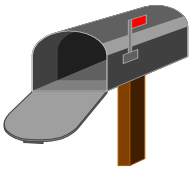
Arizona Health Care Cost Containment System

July – August, 2001

ENCOUNTER KEYS

INSIDE THIS ISSUE:



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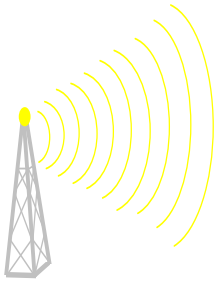
AHCCCS' FTP INPUT PROGRAM CHANGE TARGETED FOR OCTOBER 2001



Effective Void/Replace processing change October 2001:

- **Duplicate logic will be removed from daily syntax processing. This means that files will no longer fail for exceeding the 4% duplicate threshold. As a result, duplicate encounters will pend for Contractor correction.**

- **Voided encounters will be processed prior to replaced encounters. This will alleviate erroneous encounter pends on voided/replaced encounters.**

WELCOME ESTER!

The Encounter Operations Unit would like to introduce everyone to our newest Technical Assistant Representative – Ester Hunt. Ester will be assisting with encounter technical questions for those Contractors previously assigned to Deborah Burrell.

Ester joins the Encounter Unit with a background in the ASC Test Unit, the Provider Unit, and Fee For Service Claims Department. Ester can be reached at (602) 417-4140.

Dilemmas

For the months of July and August, pended encounters with the following error code conditions are not sanctioned.

A950 – Data Gathering Error

This edit is due to AHCCCS system enhancements. It is anticipated that most of the encounters currently pending for A950 will be reprocessed during subsequent encounter cycles. Sanctions will be waived on any encounters delayed because of this issue.

S385 – Service Units Exceed Maximum Allowed (pertains only to the 80000 procedure codes).

REVIEW OF ENCOUNTERS ADJUSTMENT PROCEDURES

The procedures for adjustments allow Contractors the ability to revise encounter records that have been previously approved (encounters in a status location of 31/78) by AHCCCSA. Encounters in a pended status (11/92) cannot be modified by these procedures. For pended encounters refer to Chapter 8 of the Encounter Reporting User Manual.

To make an ADJUSTMENT to Forms A, C or D the Contractor must have the AHCCCS Control Record Number (CRN). This number is entered in the Original CRN field. (Refer to the Encounter File Specifications in Chapter 5). In the Adjust Code field, enter the value "A" for Forms A and C, or "6" for Form D to indicate that the encounter is to be adjusted.

Contractors can adjust all data fields on these form types with two exceptions: the Provider Identification number and the Contractor identification number. A successful adjustment will cause the original encounter to be updated with the new data.

To make an adjustment to a Form B (UB-92) encounter the Contractor must have the CRN of the original encounter. This is entered in the Original CRN field, located on Document Header 9. (Refer to the Encounter File Specifications in Chapter 5). In order to indicate that an adjustment is requested, a bill type of XX6 must be entered. The X in the first two digits of the bill type must be numbers between 1 and 9, where the first digit is the facility code and the second digit is the bill classification code.

Limitations for Adjustments are as follows:

- Revenue codes CANNOT BE ADDED OR DELETED.
- Contractors are required to send the same number of revenue code lines on the adjustment record as were previously submitted.
- **Contractors cannot change the PROVIDER or CONTRACTOR identification numbers (Health Plan Id).**
- Contractors cannot adjust an encounter that has been previously withdrawn (location status 42/78 by the Plan or denied (location status 41/78).

For additional information, refer to the Encounter Reporting User Manual Chapter 9.

ERROR CODE UPDATE

****New Error Code****

T316 – BHS Rate Not on File
(Applicable to ADHS ONLY)

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Error Code Changes

Effective with dates of service on and after 10-01-2001 the following edits will pend instead of auto denying:

H270-Prior CRN not found or mismatched

H280-Encounter not eligible to adjust

H290-Adjust/void code invalid

H610-Previous CRN and adjustment/ void code not both present, are currently sent to pend and should be handled in the same manner.

Encounters pending for these edits will must be voluntarily deleted and resubmitted.

ON-LINE

VOLUNTARY DELETES

Contractors now have the ability to delete encounters on-line in the AHCCCS PMMIS system. This done by entering “X899” in the DENIAL REASON field and then confirming the action by Pressing “PF9”.

If you need assistance contact your Technical Assistant.

CORRECTED RATE

The rate for J2915, Injection; Sodium Ferric Gluconate Complex In Sucrose Injection, 62.5 MG (Ferrlecit) has changed from $7.74 to $40.85.

This is a correction for the 04/01/2001 rate.

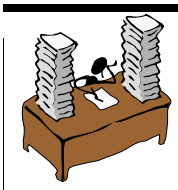
UB-92 DATA

UB-92 encounters should not contain zero ($0.00) billed charges.

Additionally, Admit and Discharge hour(s) must be reported when required and should be reported when applicable.

The Patient Status field should be reported on outpatient encounters where applicable. If you have any questions please contact your Technical Assistant.

When submitting UB-92 encounters **you must include the total line (001) for the encounter to be adjudicated.**



HIGH PENDS FOR SPECIFIC ERROR CODES

There has been an extremely high volume of pended encounters for the following error codes. If you need assistance, contact your Technical Assistant.

R295 – Medicare Reported But Not Indicated
R600 – Medicare Coverage Indicated But Not Billed

For pending encounter for the above Medicare edits please review the following:

Recipient has Medicare

If the recipient has Medicare, the system logic will look for a numeric value in the appropriate Medicare fields. If those values are missing, the encounter will pend for R600 (Medicare indicated not reported). If Medicare covers the service, the allowed value should be greater than zero (payment may equal zero if full allowed amount applied to deductible); if Medicare does not cover the service, the allowed and paid value should equal zero. A zero value indicates that Medicare did not cover or denied the service.

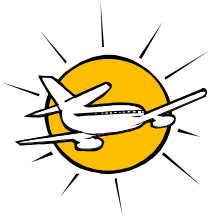
Recipient does not have Medicare

If the recipient does not have Medicare, the system logic expects the appropriate Medicare fields to be blank, i.e., have no value. If values, other than blank are submitted in those fields, the encounter will pend for R295 (Medicare reported but not indicated).

WHAT IF

- If the AHCCCS recipient file indicates that the recipient has Medicare and according to your information the recipient does not have Medicare, the Division of Member Services (DMS) asks that a TPL form (example in July-August 2000 Encounter Keys) be submitted to AHCCCS Administration. The encounter will pend for R600 until the AHCCCS recipient file is updated.
- If the AHCCCS recipient file indicates that the recipient does not have Medicare and according to your information the recipient has Medicare, the TPL form should be submitted to AHCCCS Administration. The encounter will pend for R295 until the AHCCCS recipient file is updated.

S385 – Service Units Exceed Maximum Allowed. The AHCCCS daily maximum units for procedures are ***only a guide***. These limits were established by AHCCCS as a point of reference to monitor the number of units submitted for certain procedure codes. If providers are appropriately submitting claims with units that exceed AHCCCS limits, submit supporting documentation to your Technical Assistant, so any pended encounters can be reviewed.



AHCCCS CHANGES REIMBURSEMENT METHODOLOGY FOR AIR AMBULANCE SPECIALTY CARE TRANSPORTS

In the past, AHCCCS' Fee For Service (FFS) rates were set to reimburse air ambulance specialty care transportation providers differently from non-specialty care transportation providers.

Effective on and after dates of service August 1, 2001 AHCCCS is changing its reimbursement methodology for emergency air transportation.

All air ambulance providers will receive the same FFS reimbursement rates for non-specialty care transports (see Table A). Providers will receive FFS reimbursement rates for specialty care (see Table B) transports when the following conditions are met:

1. Provider must have current MTP/NICP (maternity transport program and newborn intensive care program) contract with ADHS, and AHCCCS must have a copy of the contract.

2. Provider must use high-risk transport team and equipment for the transport.

3. Provider must send supporting documentation for maternity/newborn intensive care transport. Appropriate supporting documentation will be reviewed prior to reimbursement, and shall include one of the following:

- A completed **Request for Participation Form** for all neonatal flights with approval from an ADHS contracted perinatologist or neonatologist with privileges at one or more of Arizona's tertiary perinatal centers; or
- A completed **Request for Maternal Transport Form** for all maternal flights with approval from an ADHS contracted perinatologist with privileges at one or more of Arizona's tertiary perinatal centers.

Specialty care transport services will be designated by the specialty modifier "**TH**" in combination with one of the following transportation codes:

A0430	Ambulance service, conventional air service, transport, one-way, base rate
A0435	Air Ambulance, Fixed-wing mileage, per statute mile
A0888	Noncovered ambulance mileage, per mile (note: this service is limited to air ambulance services for members with dual Medicare/Medicaid eligibility)
A0431	Ambulance service, air, helicopter service, transport, base rate
A0436	Air Ambulance, Helicopter mileage, per statute mile

In addition, the code A0225 (which replaces Z3660 and will be used for the maternal/neonate transport team ground ambulance - per trip) can only be used by specialty care providers. A0225 should not be reported with the TA modifier.

Additional information may be found in the Air Transportation Memorandum dated July 26, 2001, which was sent to all CEO's and Administrators.

Table A
NON-SPECIALTY CARE TRANSPORTATION

Description	HCPCS	2001 Fee
Ambulance service, conventional air service, transport, one-way, base rate	A0430	$1,081.10
Air Ambulance, Fixed-wing mileage, per mile	A0435	$ 8.82
Non-covered ambulance mileage, per mile	A0888	$ 8.82
Ambulance service, air, helicopter service, transport, base rate	A0431	$1081.10
Air Ambulance, helicopter mileage, per mile	A0436	$ 19.43

Table B
SPECIALTY CARE TRANSPORTATION

Description	HCPCS	Modifier	2001 Fee
Ambulance service, conventional air service, transport, one-way, base rate	A0430	TH	$2,484.91
Air Ambulance, Fixed-wing mileage, per mile	A0435	TH	$ 21.15
Non-covered ambulance mileage, per mile	A0888	TH	$ 21.15
Ambulance service, air, helicopter service, transport, base rate	A0431	TH	$2,484.91
Air Ambulance, helicopter mileage, per mile	A0436	TH	$ 39.60
Maternal/neonate transport team ground ambulance (per trip)	A0225		$ 844.62

TRANSPORTATION BILLING

Emergency air transportation providers may report non-covered mileage to the AHCCCS Administration using HCPCS code A0888 (Non-covered ambulance mileage, per mile [e.g., for miles traveled beyond closest appropriate facility]). This code may only be used when billing for services for Medicare members.

Ground ambulance providers are restricted from billing this code for Fee For Service (FFS) claims effective dates of service on and after March 15, 2000. Ground ambulance providers must use the AHCCCS – specific code Z3655 to report non-covered mileage.

The AHCCCS-specific code Z3716 (Non-ambulance transportation; per mile) may only be used to bill for non-emergency **Air** transportation services. All ground transportation providers are restricted from using this code.